Ex. 45

NEW YORK CITY HEALTH & HOSPITALS CORPORATION
HARLEM HOSPITAL CENTER
506 Lenox Avenue
New York, N.Y. 10037

117-25-04 Unknown Female #1
[illegible] JOSEPHINE
7-17-90 117 2500

ADMISSION HISTORY AND PHYSICAL EXAMINATION

SERVICE TRAUMA ATTENDING MD Giuliani RESIDENT MD Nailoh
DATE & TIME 7/17/90 INFORMANT
CHIEF COMPLAINT
Patient sustained GSW to face, chest and upper extremities

HISTORY OF PRESENT ILLNESS:

57 yr. old hispanic female came to the ER by EMS with the history of sustained multiple GSWs to the face, chest and upper extremities.

Patient was reportedly hypotensive at the scene and arrived with MAST pants on. The patient was hemodynamically stable on arrival and was bleeding from facial injury which was controlled with pressure. She was subsequently intubated to secure the airway. After stabilization with fluids and vital signs the MAST pants were deflated. Patient is conscious but agitated.

289

61

[redacted]

Chart No. ________ 117-25-00 F.

HOSPITAL Harlem 961701-0

MENDEZ JOSEPHINE

PROGRESS RECORD 9-8-32 3

Name MENDEZ Joseph 7-17-90 Admitted ________ 19____ Ward ____

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/17/90 Plan: Admit to SICU
Hemodynamic support
ventilatory support
(Pt) to be followed by Trauma, orthopedics, and oral surgery
[signature]

7/18/90 Orth
Intubated
(L) UE ō splint
x-rays & treatment plan reviewed with Dr. [illegible]
Will splint current ulnar gutter splint and repeat x-rays
[signature]

7-19-90 X-Rayed Chest Portable C[illegible]

7/18/90 SICU RESIDENT'S NOTE
(Pt) awake, alert and responsive
(Pt) transfused 2U PRBC for HCT of 23%.
~~Vitals~~ are hypotensive from acute blood loss
Vitals: BP 120/70 Tmax 99.4 P-118 R-15
CVP 6 cm H2O

Continue Notes on Oth[er]

305

NEW YORK CITY HEALTH AND HOSPITALS CORPORA[TION]

447

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Division _____ HISTORY

Name _____ Admitted _____ 19__ Ward _____ Chart No. _____

Lungs: clear bilat
vesicular breath sounds
Abd. soft
BS+ and normal.
Extremities. (L) forearm splinted
no neurological deficit
(R) radial pulse absent, good
capillary refill all fingers

Labs 7.43 | 31.5 | 100 | 97.7 | 21.1
ABG 12 FiO2 40% 4700

CBC 22.7 > 8.0 < 173 (pre transfusion)
23.0

PT 12.1 / 11.6

138 | 103 | 19 / 152.
3.8 | 28 | 0.9

CXR ET in (R) main bronchus.
adjusted
pt put IMV mode.
Imp. Stable
Plan Wean off vent slowly
Check post-transfusion H+C
Raquel

306

493

Chart No. ______ [redacted]

HOSPITAL Harlem

117-25-00 F.

PROGRESS RECORD

5817701-0

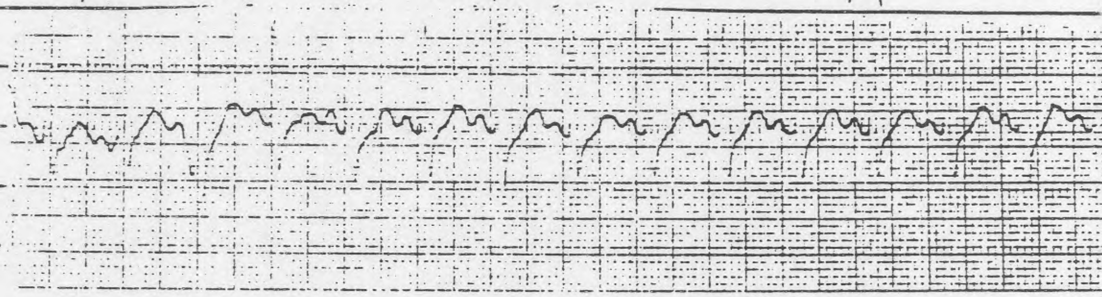
Name J MENDEZ M... Admitted ______ 19__ Ward

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7-17-90

7.17.90 Nurses notes Tour III

10pm admitted a yr old hispanic female w/c ...
c̄ a dx of multiple GSW, orally intubated - ambued
vigorously per oral ET by Dr. Nwillah assisted by Dr. Oha
jekwe. Transferred to AICU - bed. Vomitted large amount
of food material. Suctioned orally by Dr. Nwillah, O...
secured by same MD. Oral ET connected to P7200 vent
c̄ the ff settings, CMV 2 12 TV 700 FiO2 40%. Attached
chest leads and connected to cardiac monitor - sample
strip below - sinus tachycardia. No ectopics. Initial v/s



HR HR HR

taken as follows: BP 120/? P. 100 R 23 T 97 F - NMA...

10^15 pm NGT inserted by Dr. Ohajekwe and connected to LWS. Pt
alert and responsive to all stimuli. Follows verbal command
Moves all extremities. With multiple GSW to face, chest and
upper extremities. Covered c̄ dry sterile dressings. Two pt.
restraints applied → ordered to prevent pt from extubating
herself. Foot part is cold to touch, with poor capillary
refill. All pulses palpable. Foley cath connected to

Continue Notes on Othe...

______ Division ______ HISTORY

Name ______ Admitted ______ 19____ Ward ______ Chart No. ______

Bod c̄ small amount of amber urine output. With an IVF of LR running wide open (from ER). NMenerver [illegible]

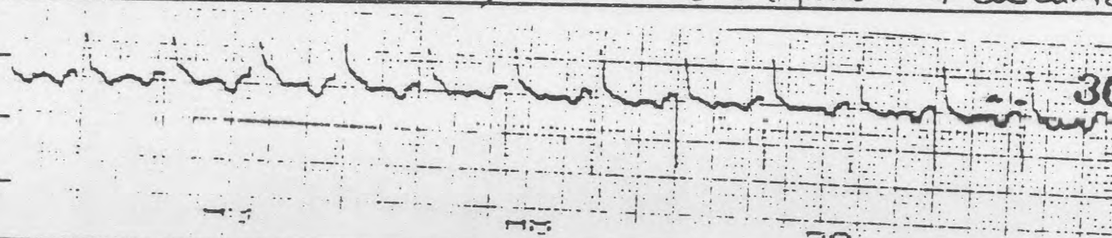
10[30] pm. Blood works and ABG done by Dr. Bosanda -- ABG result as follows: PO2 100%. pCO2 31.5 ph 7.43 O2 vol. 97.7

HCO3 21.1 BE -2.5 -- Seen by Dr. Jelma of ortho surgery - Arm splint applied by same MD on (R) lower arm. NMenerver

11pm. BP 72/0 P. 131 R. 14. CVP. 4-5 cm H2O - Dr. Bosanda made aware - Given an IV fluid challenge of LR in IV wide open - P#1 - ineffective breathing pattern R/T disease entity "GOAL" pt. will attain adequate ventilation - ABGs with normal range. To be assessed and [illegible] extubated c̄ in 1-2 days. - PLP #1 - maintain present ventilator settings. Suctioned Q1H and prn - monitor ABG results. P#2. hypovolemic R/T massive blood loss sustained from GSW - GOAL - pt. will have adequate perfusion to vital organs. BP will be maintained c̄ in normal range. PLP #2. Monitor BP Q1H and CVP Q 2H as ordered. Regulate IVF @ desired rate. - IP#1 - Suctioned scanty whitish c̄ blood tinged secretion. Noted tongue laceration while doing oral suctioning. IP#2. IVF presently infusing well @ a wide open rate. Closely monitored. NMenerver [illegible]

11[40] pm. Remain alert and responsive to all stimuli. BP re-checked. 110/80 - NMenerver [illegible]

7.18.90 12 MN - No changes in neurological status - IP#1 On continuous mechanical ventilation c̄ same parameters. Suctioned scanty whitish secretions. CP documented below



308

450

Division HISTORY

Name Admitted 19 Ward Chart No.

1 55 P BP = 120/60 T = 101.4 HR = 116 RR = 12

SIMV = 6 / ABG RESULTS - CLIENT RESTLESS -

2 15 PM - DEMEROL 75 mg. IM ADMINISTERED FOR PAIN

3 P - RESTING COMFORTABLY @ PRESENT - [illegible] p.

IP #1 PULMONARY TOILET WITH N/S IRRIGATION DONE q 1°

+ PRN - SUCTIONED LOOSE MUCOID SECRETIONS -

IP # 2 - CVP - 12 cm. 8 H U. OUTPUT = 2100 cc Sp. Gr. =

1000 - 1004 - NF CHANGED TO D5 N/S @ 100 cc 1° -

ACCURATE I + O DONE [illegible]

5 P - SLEEPING @ THIS TIME - BREATHING WITH SIMV -

VOIDING VIA FOLEY CATHETER ↓ OUTPUT

7 P - COMPLETE AM CARE RENDERED - DRESSINGS OVER

OPEN WOUND CHANGED - HEAD PART WRAPPED WITH

LINING [illegible] OOZING WITH SMALL AMOUNT OF BLOOD -

9 P IP #1 PULMONARY TOILET WITH N/S IRRIGATION q 1°

+ PRN - SUCTIONED LOOSE MUCOID SECRETIONS

10 P - PRBC STARTED BY DR. DONALDSON - X CHECKED

WITH MR. N. MENESES - NaCl - HANGED TO FLUSH

BLOOD LINE - [illegible]

11 P - PRBC CONSUMED - NO TRANSFUSION REACTION NOTED -

- E#1 - BREATHING WITH SIMV = 6 - BILATERAL BREATH SOUNDS

- E#2 - ACCURATE INTAKE + OUTPUT DONE - [illegible]

7/19/90

NURSES' NOTE

[illegible] Received pt. [illegible] posture sleeping, arousable, responsive to all stimuli follow verbal command; ventilating via oral ET to [illegible] [illegible] respiration [illegible] the following setting as SIMV 6 TV 700 FiO2 40% breathing @ the rate of 16/min, [illegible] chest expansion breath sound present [illegible] quantities; [illegible] [illegible] connected to [illegible] draining [illegible] [illegible] color output; abdomen soft [illegible] not distended [illegible] hypoactive bowel sound present, [illegible] [illegible] dressing [illegible] elevated [illegible] pillow [illegible]

310

451

Division HISTORY

Name Mendez Josephine Admitted 19 Ward Chart No.

7/19/90 NURSES' NOTE

11-00 NGT residual check c only 30cc returned, [illegible]

[illegible] [illegible] by ortho consult, [illegible] Dr [illegible] and

[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] recent

ABG PO2 125 PCO2 41 HCO3 24. Sat 98. ph 7.3, — mcastwan

2p wounds the rt face, [illegible] [illegible] area; cleaned c betadine

dressing changed, [illegible] placed, wounds the rt. arm

cleaned c betadine dressing changed, drainage scanty serosang.

drainage noted, oral care done, pt. encouraged to turned to

side able to [illegible] [illegible] [illegible] [illegible] on side lying

position; back skin intact; [illegible] done 100 mg [illegible]

3p alert, communicate by writing, [illegible] [illegible] [illegible] [illegible]

I&O [illegible] & recorded, due IVSS med given, recent CVP 8-9

cm H2O; NGT feeding started c osmolite 1/2 strength [illegible] 30cc/hr

as ordered; left arm [illegible] elevated c splint — c bandage dressing;

[illegible] [illegible] stable c [illegible] — [illegible]

3:30 Chest x-ray done [illegible] by technician — mcastwan

7/19/90 SICU RESIDENT'S NOTE

(PE) awake, alert, responsive communicating by writing

BP 130/80 Tmax 100.1 P-110 R 15

CVP 8-9 cm H2O

PFTs done - VE ~~7.93~~ Vt ~~466~~cc NIF -45 rate 17

~~Lungs~~ vesicular breath sounds bilat.

Abd soft

BS+ and normal

Ext (L) forearm splinted; good cap. refill (L) fingers

452

Chart No. _____

HOSPITAL _____

117-25-0u F.
961701-0
MENDEZ JOSEPHINE
0-0-00

PROGRESS RECORD

Name _____ Admitted 90 19____ Ward ____

Observations and Opinions of Visitings, Consultants and House Staff.
A final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

CBC 18.6 / 12.0 / 35.2 \ 138

CK. 1009 MM

SMA7 138 | 107 | 14 \ 96
3.8 | 21 | 0.7

LFT Bil - 2.1
SGOT / SGPT -- 55 / 28

ABG 7.38 | 127 | 41 | 98.6 | 242
FIO2 40% | MV4 @ 700

Imp: Hemodynamically stable
mandible fx to be f/u by ord surgs
keep ET

Bernal

TOUR III 7-19-90

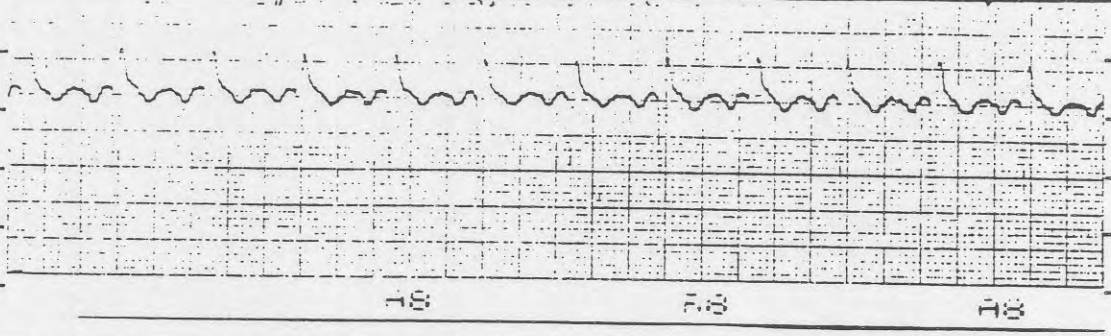
4P - seen pt. on semi-fowler's position, awake & responsive all stimuli, follows simple command like "squeezing nurse's hand, c NAD to feeding of 1/2 S densolite @ 30 cc/h. dressing intact, orally intubated to 1200 microprocessor c ventilator settings as follows FT - 700 FIO2 40 % SIMV 4. symmetrical chest expansion noted. c coarse breath sounds on auscultation. IVF through K.S. D5 1/2 NS ; L + 20 mEq KCl @ 50 cc/h. dressings on chest intact & dry ; dressings on (R) upper extremities dry & intact. (L) arm c splint wrapped in ace bandage. able to move all extremities. abdomen soft & not distended. positive for bowel sounds. ____ Foley

Continue Notes on Other Side

Division HISTORY

me Admitted 19 Ward Chart No.

- chest leads intact attached to cardiac monitor, alarms set
- @ 50-150. strip taken & shown below. on sinus tachy cardia BPM - 115.



- foley catheter intact draining well light orange output.
- moderate in amount. peripheral pulses palpable.
- skin warm & dry to touch. visitors @ bedside.
- suctioned ET to loose whitish return. pulmo-
- nary toileting done c NS. ——— galbert rn

6a - temperature checked - 100.1. cooling measures done.
8P - pt. sleeping c this time. given Keflex 500 mg stat
8:15P c - through NGT as ordered. ——— galbert rn

Oral & Maxillo facial Surgery:

2/19/90

Still intubated on SIMV. Swelling on the face is decreasing - patient is responsive and alert; vital signs are stable. Anterior mandibular fracture is palpable with tenderness. Mucosal tear at the anterior mandible. Full intraoral exam is incomplete because of endotracheal tube. 6p: At this time instructed treatment is closed reduction with external skeletal pin fixation on 2/20/90. -- Additional radiographs are however needed of the facial bones.

454

Chart No. ____________ HHC

HOSPITAL ____________

117-25-00 F.
961701-0
MENDEZ JOSEPHINE
9-8-32

PROGRESS RECORD

Name Mendez Josephine Admitted ____________ 19____ Ward ____

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

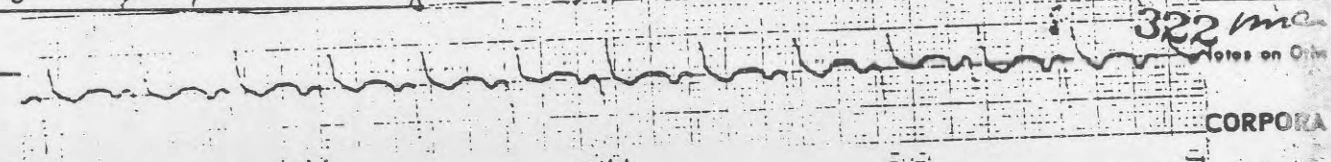
7/10/90 NURSES' NOTE

8a a.m. care done; kept clean & dry, pt encouraged to turn [illegible]
7a awake, alert, responsive to all stimuli; [illegible] throughout the day, c minimal [illegible] chest [illegible], [illegible] and [illegible] respirations, no SOB noted @ present; ETT [illegible] sleeping; no pain [illegible] @ present. ―――――――― [illegible]

9a continues care done; needs attended to: [illegible] [illegible]; [illegible] c white [illegible] [illegible]; pt encouraged to cough & [illegible] [illegible] c [illegible]; a [illegible] throughout the day @ [illegible]; [illegible] pt complained of [illegible] a [illegible] chest; c [illegible] complaint of SOB; BP 120/70 P 119
9:05a [illegible] given c Demerol 50mg @ [illegible]; [illegible] the rate of 15-20 [illegible]; [illegible] the [illegible] face; [illegible] [illegible] [illegible] left arm c [illegible] [illegible] [illegible] [illegible] [illegible] a pillow; ―――――――― [illegible]

10a a [illegible] @ 30- [illegible]; all [illegible] given. [illegible] [illegible] given by [illegible]; all [illegible] [illegible] all [illegible] [illegible] 120-[illegible]. [illegible] 7-8 [illegible] c foley catheter to gravity drainage adequate dark [illegible] [illegible] SAO[illegible] ETT sleeping @ present; pain slightly relieved ―――― [illegible]

Ka vital signs stable on continuous cardiac monitor. [illegible] [illegible] [illegible] [illegible], [illegible] [illegible] [illegible]



322

Notes on Oth[er]

CORPORA[TION]

455

HHC
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

HISTORY

_______ Division _______

Name Mendez, Josephine Admitted _______ 19___ Ward _______ Chart No. _______

7/20/90 NURSES' NOTE

2p GSW [illegible] — face, chest and arm cleaned and external dressing changed, with serosanguinous drainage, with [illegible] [illegible] face dressing; TPN and care done, suctioning done with [illegible] [illegible] with [illegible] fluid [illegible] secretion; [illegible] wheezing [illegible] Aminophylline drip; [illegible] [illegible] Tx given; [illegible] care done perineal care done; kept clean & dry ——— [illegible]

2:30p pt vomited placed in [illegible] position; with coffee ground [illegible] small amount; NGT [illegible] hold, NGT connected to LOW wall suction draining [illegible] coffee ground [illegible], Dr [illegible] & Donaldson at bedside [illegible] pt. ——— [illegible]

2:40p [illegible] — [illegible] position, dressing around face changed

3p [illegible] ET [illegible] — [illegible] [illegible] still complaining of [illegible] pain [illegible] chest, alert, [illegible] to all [illegible], [illegible] at bedside; M.D. & Family discussing about discharge against medical advice; Aminophylline drip D/C, IV fluid changed to D5 1/2 NS [illegible] KCl @ 100 per [illegible] subclavian line, [illegible], [illegible] IVSS [illegible] given as [illegible] BP 140/80 P112 R19/m ——— [illegible]

3:30p planning [illegible] pt family & discharge pt against medical advice D/C, after [illegible] to Dr. Donaldson; [illegible], Dr. Donaldson [illegible] consent for tracheostomy & fixation of mandibular [illegible] [illegible] wiring after explaining the procedure, its advantages & disadvantages of the operation; pt husband signs the consent. ——— [illegible]

3:40p pt tachypnea [illegible] [illegible] [illegible] complaining of pain, Dr Donaldson [illegible] at bedside, [illegible] [illegible] given Demerol 50 mg IM as [illegible] done; BP 120/80. 323

——— [illegible]

456

Chart No. ___ 117-25-00 F.

HOSPITAL Harlem 961701-0

MENDEZ JOSEPH.NE

PROGRESS RECORD 9-8-32 S

Name Mendez, Josephina Admitted 90 19___ Ward

7/20/90 (Cont) Observations and Opinions of Visitings, Consultants and House Staff. A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

NC EP#1 Suctioned & irrigated. No resp. distress noted. ABG's monitored ———

EP#3 No c/o severe pain this P.M. ———

Condition guarded. Endorsed — [illegible]

M. DOMINGO RN

7/21/90 NURSES' NOTE

12^30 Received pt. sleeping arousable; alert & responsive to all [illegible] head elevated @ 45°, following command; communicates by [illegible] ventilating via oral ET to 7200 Bennett respirator on the following setting as SIMV 4 TV750 FIO2 40% breathing @ the rate of 16/min, [illegible] intact on LWS draining moderate amt of [illegible] output; abd soft & not distended [illegible] bowel sound present, [illegible] wound dressing on the face & [illegible] area, [illegible] foul odor [illegible] the mouth, [illegible] done [illegible] & NS, [illegible] dressing [illegible] chest & [illegible] in place & dry; left arm [illegible] splint [illegible] to the arm kept elevated on pillow, IV fluid [illegible] line infusing well; vital signs taken & recorded; IPPB/pulmonary toilet done [illegible] secretion [illegible]; pt encouraged to cough & take deep breathing; [illegible] auscultation; no SOB complained of [illegible]; ——— [illegible] low grade fever [illegible] 99.3F, [illegible] 120-80 [illegible] foley catheter to gravity draining adequate u/o; [illegible] CVP 7-8 cm of H2O, all pulses [illegible] palpable, able to move all ext. [illegible] given [illegible] 30/min ——— [illegible]

Continue Notes on [illegible]

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

457

HHC 120-203 (JAN 73) REPLACES SR 5004 WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

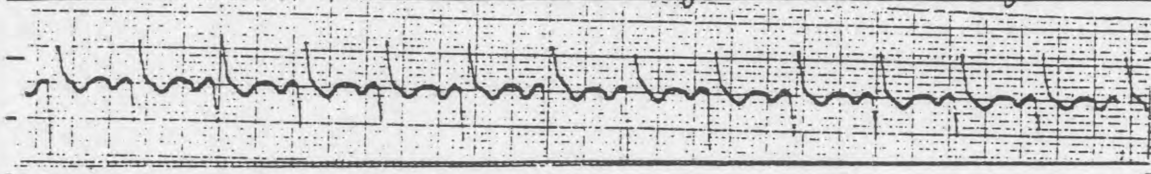
-2

Division — HISTORY

Name: Mendez Josephine   Admitted ____ 19__ Ward ____ Chart No. ____

7/21/90 NURSES' NOTE

3a on continuous cardiac monitor, ECG strip documented below, alarm set between 50-150/min, in sinus tachycardia, no ectopic beats noted



H8 H8 H8 F18

3[illegible] dressing - Rt left arm reinforced, wound in Rt face mandible area, chest upper arm cleansed with peroxide & betadine, dressing changed

4a oral care done with peroxide & NS, tape around the ET changed, dressing around the face changed and wrapped with kling bandage. [illegible] pt complained of pain while changing the wound, dressing [illegible] med given: Demerol 75mg & Vistaril 25mg @ as ordered — [illegible]

4[illegible] BP 120/70 P110 R24/min [illegible] sleeping at present, pain slightly relieved. [illegible] PVC's noted in the monitor, on sinus tachycardia [illegible]

5a pt sleeping BP 90/[illegible] P120 R24 placed in flat position, [illegible] [illegible] MD aware [illegible]

6a [illegible] care done, perineal care rendered, [illegible] 99°F, able to [illegible] to [illegible] assistance, [illegible] to bed, [illegible] then changed for 30 min only. I&O measured & recorded, [illegible]

7a head elevated at 45°, alert, responsive to all stimuli, follows command, [illegible] ET [illegible] in [illegible] [illegible] setting, [illegible] kept elevated in pillow, [illegible] sleeping at present, still c/o mild pain - Rt left arm & chest [illegible]

7[illegible] K level 3.5, K supplement given as ordered: KCl 20 meq - Dr. [illegible] [illegible] as ordered [illegible]

330

458

Division _____ HISTORY

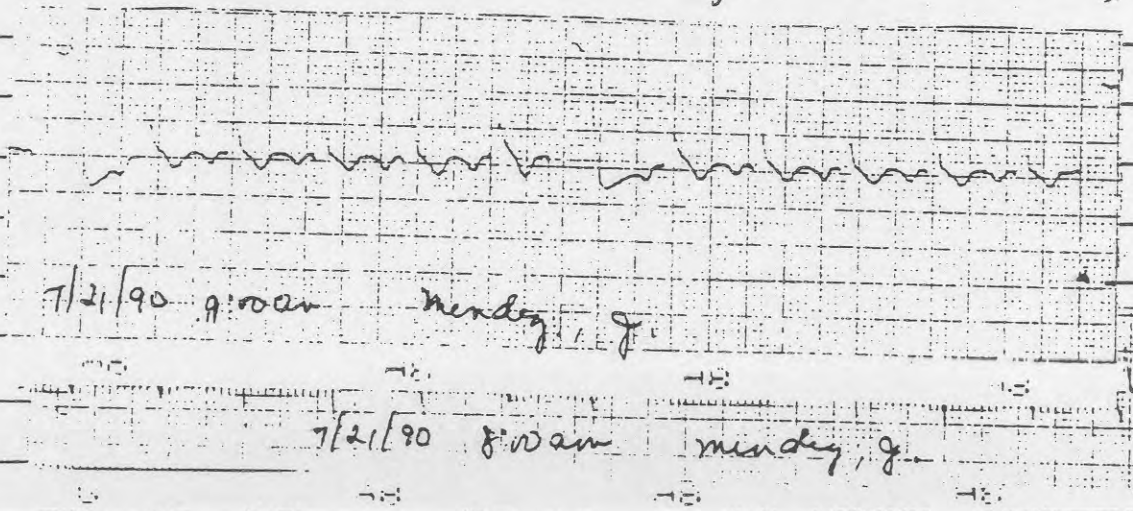
ame _____ Admitted _____ 19__ Ward _____ Chart No. _____

7/21/90 8:00 am Nurses Notes Tour II

Patient remined awake and responsive to all stimuli. With ~~head~~ nasogastric tube in place and clamp. Orally intubated and ventilated via 7200 ventilator c TO 700 FIO2 40% SIMV 4/min. Equal chest excursion + breath sounds noted. With (R) subclavian line in place and receiving IVF of D5 1/2 NS + KCl @ 90 meq/kg at 70 Occ/hr. IVF infusing well. With splint on (L) arm in place. Both upper extremities elevated c pillow. Chest leads in place and connected to cardiac monitor. Cardiac pattern documented below. Pattern shows normal sinus tachycardia. Abdomen soft c (+) bowel sounds. Foley catheter in place and draining with yellow urine output. Able to move all extremities voluntarily. _____ ge. orig Rn

7/21/90 9:00 am P#1 Ineffective breathing pattern RT accumulation of secretions. IP#1 Pulmonary irrigation + suctioning done. Maintain on mechanical ventilation with attempts to wean off. EP#1 On SIMV 4/min. Appears comfortable, shows no signs of respiratory distress. _____ ge. orig Rn

7/21/90 P#4 alteration in cardiac pattern RT unknown etiology. Goal #4 Prevent further complications. PL#4 Monitor occurrence of PVC's. IP#4 Refer to M.D. for occurrence of PVC's. administer



334

454

________ Division ________ HISTORY

ne ________ Admitted ________ 19____ Ward ________ Chart No. ________

7/21/90 2:10pm Nurses Notes Tour II

reminded to cough. aggressive chest PT done. ——— ge. ng Rn

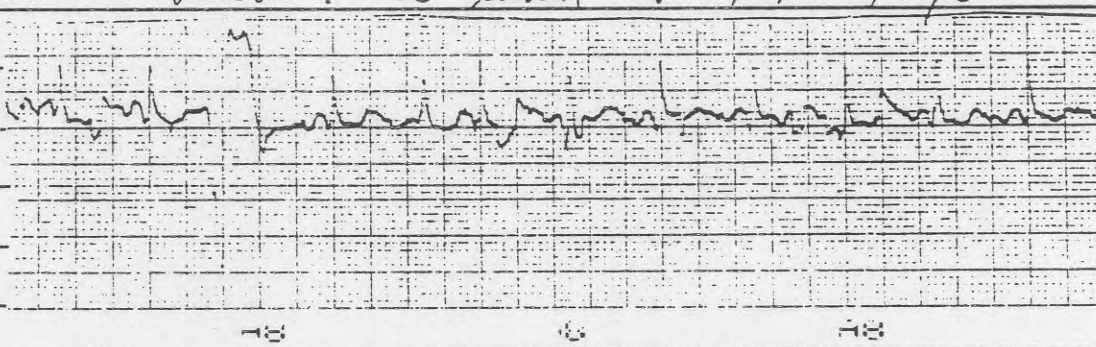
7/21/90 3:00 NGT ~~drainage in 5~~ aspirated to check residual. ~~the~~ obtain 10cc of yellowish to greenish drainage. Dr. Donaldson aware. Blood gas done. ——— ge. ng Rn

7/21/90 3:30pm flexiflo inserted by Dr. Donaldson to start feeding. ABG result as follows: PO2 - 93.9 PCO2 - 32.2 Ph - 7.494 % sat - 97.7 HCO3 - 24.7 - Maintain on 40% aerosol mask. X-ray requested to confirm NGT placement. ——— ge. ng Rn

7/21/90 Nurse's Notes

4p Neuro: Alert & responsive to all stimuli, oriented X3 spheres, coherent. —

Cardiac; On EKG monitoring c̄ strip taken & documented below. VS taken as BP - 120/80 P - 86



R - 26. c̄ IVF D5 1/2NSTL + 20 meq KCl @ 100cc/H via (R) subclavian intact, & infusing well. Peripheral pulses palpable. —

Resp: Ventilating on O2 via aerosal mask @ 40% continuously. Tolerated well. P#1 Ineffective breathing pattern R/T disease entity: EP#1 expectorating to yellowish thick, moderate secretions. No resp. distress noted.

GI: c̄ NGT in place, patent & clamped, still awaiting for X-rays result for placement. [illegible]

Chart No. _____

HOSPITAL _____

PROGRESS RECORD

117-25-00 F.
961701-0

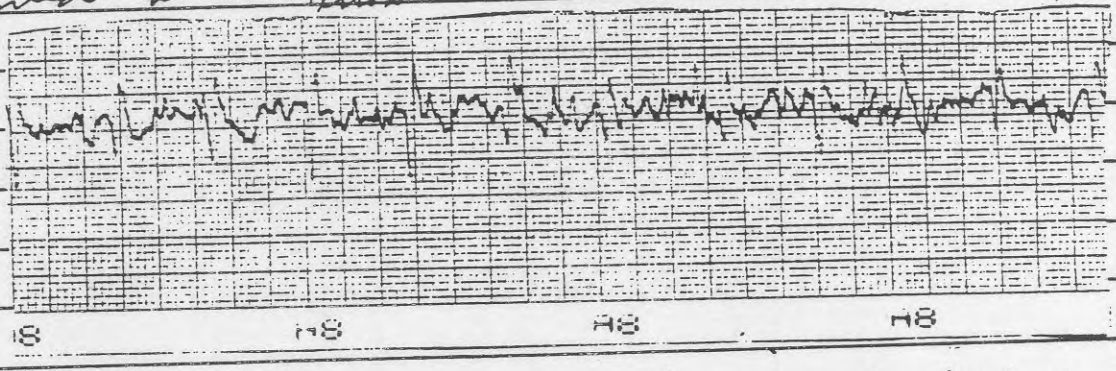
Name MENDEZ JOSEPHINE Admitted _____ 19____ Ward ____

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/22/90 Nursing notes

12Am Neuro: Alert & responsive to all stimuli, no unusual changes in LOC. Oriented x 3 appropriate.

Cardiac: As EKG monitoring & temp taken and documented below. BP taken & documented below. VS



As BP-100/70 P-110 K-24. Peripheral pulses palp. EKG alarm setting @ 50-150/min.

Resp: Ventilating on room air. Tolerated well. FP#1 no acute respiratory distress noted, had bouts of productive cough, expectorating thick yellowish secretions, moderate.

GIT: C NGT in place, patent connected to duodenal feeding 1/2 strength @ 50 c/hr via kangaroo pump. Tolerated well. Abdomen soft, not distended. Bowel sounds (+)

GUT: C foley cath to BSD bag by gravity C moderate amber urine output.

Continued Notes on Ch

342

NEW YORK CITY HEALTH AND HOSPITALS CORPOR

461

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Chart No. ________

HOSPITAL ________ HHC

117-25-00 F.
961701-0
MENDEZ JOSEPHINE

PROGRESS RECORD

Name Mendez, Josephine Admitted ________ 19____ Ward ____

Observations and Opinions of Visiting, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/22/90 cont. Nurses' notes
2Am BP-120/70 P-100 R-24. Chemstrip 120-180 mg/dl
SAD. negative. T-98.3. Resting quietly. —
3Am Due medications administered as ordered by MD
Tolerated well. No unusual. EKG changes noted
4Am AM care rendered c total assistance.
Linen changed & made comfortable in bed. cooperative
Dressings on arms, chest & face changed & dressed
c saline under aseptic techniques. —
5Am VS steady, asleep. —
6Am CVP 6-7 cmH2O. Chemstrip 120-180 mg/dl.
Due medications administered as ordered by MD
tolerated well. —
7Am I&O measured & recorded. CP #1 No acute
respiratory distress noted. CP#3 No complaint of
pain made throughout the shift — [illegible]
9/22/90 8:00 am Nurses Notes Tour II
Patient received alert & awake, responsive to all stimuli. Ventilating on room air. Not in any signs of distress. With feeding tube in place receiving osmolite 1/2 S at 50cc/hr. With (R) subclavian line in place. IVF infusing well. No signs of infiltration noted. Chest leads in place and connected to cardiac monitor. Cardiac pattern documented below. Pattern shows normal sinus rhythm with unifocal PVC's. M.D. aware & patient
ge. ong pa

344

Continue Notes on Oth

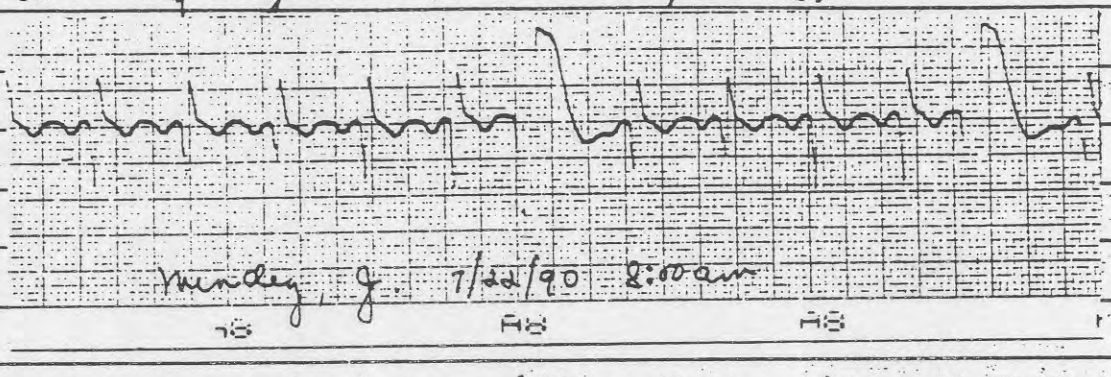
NEW YORK CITY HEALTH AND HOSPITALS CORPORA

462

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

7/22/90 8:00 am Nurses Notes Tour II

was seen by ~~cardiac~~ medical consult. No recommendations made. States PVC's are benign. With multiple gun shot wound on face. With dressing in place. Abdomen soft ē (+) bowel sounds. Foley



catheter in place draining with yellow urine output. able to move all extremities voluntarily. With splint in place on (L) arm. Patient complained of numbness on fingers on (L) hand ē splint. No cyanosis noted. With good sensation ē brisk capillary refill noted on affected arms. Dr. Donaldson aware. gf. ang RN

7/22/90 9:00 am P#1 Ineffective breathing pattern RT accumulation of secretions. EP#1 Problem resolved. Ventilating on room air. Nasal mask discontinued. ——— gf. ang RN

7/22/90 10:00 am P#4 alteration in cardiac pattern RT unknown etiology IP#4 Monitor cardiac ~~monitor~~ pattern. Assess patient for any signs of cardiopulmonary difficulties. EP#4 still ē unifocal PVC's, patient remains asymptomatic, no complaints of chest pain ——— gf. ang RN

7/22/90 11:00 am To start ~~of~~ clear liquid diet for lunch —— gf. ang RN

7/22/90 12:00 N - Patient alert at intervals. No complaints presented.

7/22/90 1:00 pm Unable to tolerate sips of clear liquid diet. Vomited fluid taken in p.o. seeps around wound on (R) chin area. Dr. re-notified. NGT feeding ē similac ½ S continued. gf. ang RN

7/22/90 2:00 pm Remained prone til treatment & tolerating well. gf. ang RN

7/22/90 3:00 Patient awake & alert. Still with PVC's unifocal - Tolerating sips of water slowly. (Ventilating well on room air). gf ang RN

463

Chart No. [redacted]

HOSPITAL HARLEM

PROGRESS RECORD

[redacted] 117-25-00 F.
961701-D
MENDEZ JOSEPHINE
9-8-32 S
1 - Admitted

Name [redacted] 19___ Ward ___

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/22/90 830 pm. OMFS Rz Follow up Note

- This is 58 YO. Hispanic female c multiple GSW to Chest, mandible ® Forearm ® humerus, © Hand. Pt is currently stable, A+OX3, responsive and extubated yesterday. Pt is now being worked up for reduction of mandible fx.

VS = T= 99.4, BP = 130/80, P=120 R=24. → 8pm
- CVP = 7-8 cm H2O
Chemstrip = 120 mg/dl.
Urine output = 600 cc
© Cheek wound → Granulating well, no discharge.
®. mandible wound → evidence of tissue breakdown c minimal discharge (yellow in c
©. Neck wound → evidence minimal tissue breakdown c minimal discharge (yellow in c
IOE = 1). mobile segment #21 – 27 4/4 mobility. No hemorrhage or discharge noted.
2). Gingiva and buccal mucosa pink and moist.
X-Ray films (Not a good diagnostic film) 346
Note fracture lines 1). proximal to #32
2). between #27-28 (oblique line to symphysis regio
3). from #22 to the Symphysis fx.

Continue Notes on Other Si

464

HHC 120-203 (JAN 731 REPLACES SR 5004

Chart No. _____

HOSPITAL HARLEM

PROGRESS RECORD

[redacted]
117-25-00
961701-0
MENDEZ JOSE
9-8-32

Name _____ Admitted 7-11-90 19____ Ward ____

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/22/90 Trauma CR fllw

Pt extubated yesterday, and appears comfortable and no respiratory distress.
BP 120/70 T 99.1 R22 PIP CVP 7-8
No more PVCs
Chest: Clear, no wheezes.
Abd: soft, not distended BS+
N/G feeding in progress.
Extr: ① Forearm splint, taken c good cap. refill
② Forearm wounds clean, and no edema
24hrs I/O 2275/2780
Labs — Hct 108/31.1 Lytes wnl
Impr: ① Stable & doing well
② Cont present Mgt and Oral Surg F/u for Mand Fx

7/22/90 3:00pm Skin breakdown noted on patient's ② & ③ parietal area. Site open to air. Area appears about 1 x 1 inch in size.
gf-ng RN

348

Continue Notes on Other

NEW YORK CITY HEALTH AND HOSPITALS CORPORA

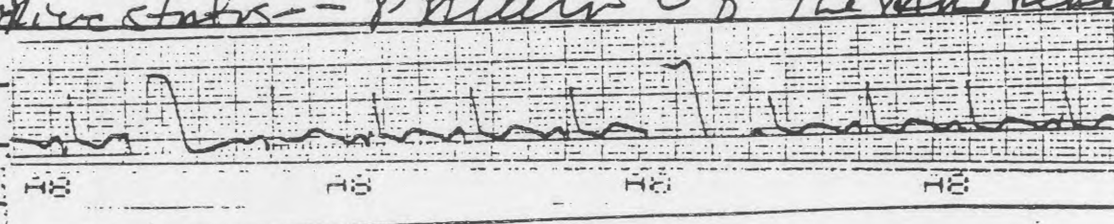
HHC 120-203 (JAN 73) REPLACES SR 5004

Division HISTORY

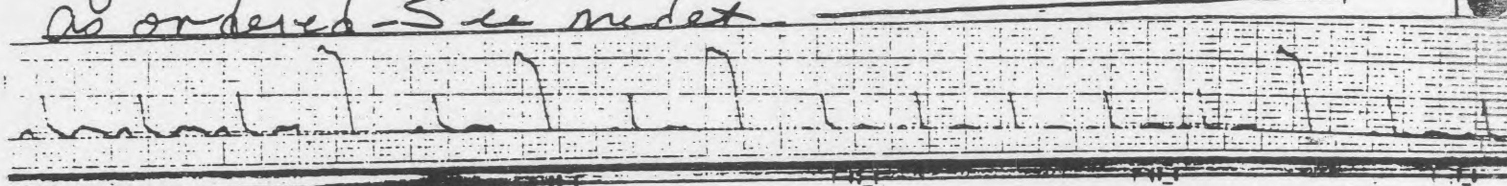
Name ______ Admitted ______ 19__ Ward ______ Chart No. ______

[illegible] Oth
Confident [illegible]
(L) HAND [illegible]
[illegible]
[illegible]

7-22-90 FOUR ## Nurses Notes
Pt Received in bed Semi fowler position
Mental Status – Responding to all stimulus
Respiratory Status – On Room Air
Urinary status – Foley cath c amber urine
draining to bag – Same as previously
Cardiac status – Pattern of the same placed below



Cardiac Monitor set & maintained @ 50-150 mm Hg.
DP #4 – Cardiac Status remain the same pattern
of the same placed below – Medication given
as ordered – See medex.



Dressing to facial & neck wounds cleansed c
NS & DSD applied – Dressing to (L) chest dry
& intact – Seen by Oral Surgery team –
facial wounds cleansed & Dressing & Ace Bandage
Applied – pt remained the same C/O soreness about
Neck –

[illegible]

117-25-06 F.
961701-0
MENDEZ JOSEPH ME
9-8-32
7 Admitted 90

Chart No. ____________

HOSPITAL HARLEM

PROGRESS RECORD

Name ____________ 19____ Ward ____

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7-22-90 Tour III Nurses Notes - Continues
Complete bed bath given - Dried cake blood
Removed from Hair on head - Oral hygiene
Given X 2 during tour - Skin lubricated
c̄ Lotion - Foley cath care done c̄ H_2O_2 & NS
pulmonary toileting done same effective - pt
Cough up thick yellow sputum (5cc) -
aerosol RX given as ordered Same effective
pt cough up more sputum & the same -
Edematous extremities elevated in rotation
Same supported c̄ pillow - dressing to (R) upper
extremity dry + intact Same maintained on pt
pt talk about experience leading to present
Hospitalization emotional support
given also spiritual advised - NGT tube
patent & in place - 1/2 Osmolyte @ 50cc/h
maintained - Same tolerated c̄ well -
no c/o pain nor gross discomfort when
question - ABGs done @ intervals -
No c/o breathing difficulty when questioned
pt made comfortable as possible. Kept
Done aware of all according and
timely - [illegible] Washington RN

Continued Notes on Other

467

NEW YORK CITY HEALTH AND HOSPITALS CORPORAT

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

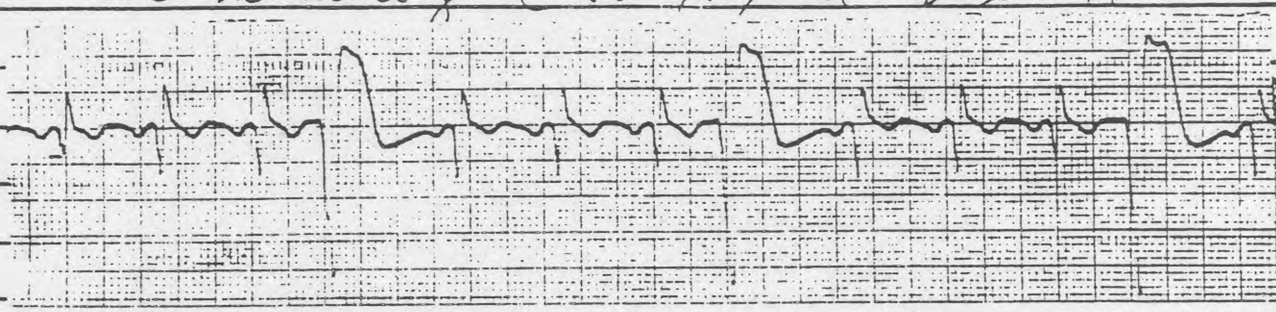
_________ Division _________________________ **HISTORY**

Name ______________ Admitted ________ 19___ Ward ________ Chart No. ________

1-3/90 Nurses' notes

12A Neuro: Alert + responsive to all stimuli, oriented X 3 spheres, coherent. —

Cardiac: On EKG monitoring c strip taken + documented below. Alarm setting @ 50-150/min. VS taken as



BP. 110/70 P-100 R-22. Peripheral pulses palpable.

Resp: On room air, Tolerated well, no respiratory distress noted. c bouts of productive cough expectorating yellowish secretions, few, ~~moderate~~. —

GI: On clear liquid diet. NPO p midnight for surgery in AM. Abdomen soft, not distended. —

GU: c foley cath. to BSD bag by gravity c moderate urine output.

Integumentary: Skin warm + dry, no edema on periabdomen noted. c multiple wound on (R) arm chest + face. Dressings intact + dry. —

1AM Resting quietly. VS stable. ~~CVP~~ 12-13 cmH2O.

2AM Chemstrip 120-180 mg/dl. BP-110/70

Afebrile T-98.2. —

3AM Due medications administered as ordered by [illegible]. Tolerated well. Wound care done, c dressings changed aseptically. Wound on face, c slight ~~drainage~~ [illegible] of greenish drainage noted. Lip care rendered. Tolerated well — [illegible] 351

463

Chart No. _____

HOSPITAL HARLEM

PROGRESS RECORD

117-25-00 F.
961701-0
MENDEZ JOSEPH NE
Admitted 7-17-90

Name _____ 19____ Ward ____

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

4. Medical consult for evaluation of Risk of G.A

5) Betadine Solum rinse (R) mandible wound and (L) Neck wound.

7/23/90 Trauma SR's: note F/U

8:25am: BP 120/80. P115. R22
I/O's 2760/3400

Pt. awake but significantly agitated and Combative, threatening to kill herself if not allowed to call her husband

Exam: Pt. refused exam.

A/P: ① Pt.'s reaction probably 2° to post-traumatic stress disorder. I do not believe that she is delirious or confused she is fully aware, and oriented to time & place.

However, psychiatric evaluation and Rx. is essential.

7/23/90 TRAUMA ATTENDING .. 352

Patient has mental extubation

Continue Notes on Order

467

HHC 120-203 (JAN 73) REPLACES SR 5004

HARLEM HOSPITAL CENTER
506 Lenox Avenue
New York, N.Y. 10037

Medical Record No.: 961701-0
Patient's Name: 117-25-00 F. MENDEZ JOSEPH NE
Location:
Date of Birth: 9-8-32 S
Admission Date: 7 . 90

Please use addressograph

RECORD OF CONSULTATION

TO: PSYCHIATRY (Service)

FROM: Surgery (Ward/Dept./Clinic) | 1340 (Tel. #)

Appointment
Date:
Time:
For OPD use only

QUESTION:

Please evaluate this 57 y o lady w/h/ c/sw to jail with open fx Mandible and multiple gun shot wounds to neck, chest and both upper extremities. (PH) hx of bronchial asthma; on and off steroids - last took steroids last year.

Requested by: K. [redacted] K. Bourgh 7/23/90
Name — PLEASE PRINT | SIGNATURE | Date

CONSULTANT'S REPORT: (also include date of return visit, use continuation form if necessary.)

Deepika Sgh R4 | Deepika Sgh R4 | 7.23.90 | 8081
Consultant's Name | Signature | Date | Tel. #

Called to evaluate patient - 57 yr old c multiple gun shot wounds + Fx of mandible. Today patient - w/ Asm became confused agitated, started pulling out IV lines etc. Patient also also has hx of asthma. on Theodur 300mg q 8hrly + hydrocortisone 100mg q. 6hrly + Antibiotics. Patient was given 5mg Valium at 5.30pm + Haldol 2mg Patient lying w/ bed sedated, unable to get any answers to any questions. Patients hydrocortisone was D/c today 353

Assessment - Patient Psychosis may be 2nd to corticosteroid

Plan - Corticosteroid has been D/c already
- Haldol 2 mg IM ~~q 8~~ stat PRN. But sedation + BP precautions should be taken. for agitation

Revised 10/25/83

[redacted] 15A

Chart No. _____

HOSPITAL HARLEM

PROGRESS RECORD

117-25-00 F.
961701-0
MENDEZ JOSEPH MF 19___ Ward ___

Name _____ Admitted 8/22/90

Observations and Opinions of Visiting Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/23/90 OMFS Follow up Note.

Lab =

$$\frac{12.0 \;\backslash\; 10.2 \;/\; 265}{\quad\; 30.3 \;/} \qquad \frac{142 \mid 109 \mid 8}{3.5 \mid 29 \mid 0.7} \;(127)$$

Theophylline level = 15.4 pt = 12.4/11.6

Medical Consult: low risk of cardiac - pulmonary complication.

UA → ϕ glucose, ϕ Ketone pH - 6-7.

7/23/90 Acm Resident

S. 20y/o female with multiple GSW - sustained bilateral mandibular fracture

O- Vital Signs BP 120/80 T 98.2 P 115 R 22.

Fluid intake 560 Sp G 1002

output 580

LAB: Na^+ 142 glucose 127 CO_2 - 24.

K^+ 3.5 urea 12.0

Cl^- 109 Hgb 10.2

Bun 8 Hct 30.3

Cr. 0.7 plt 265.

354

Continue Notes on Other

471

NEW YORK CITY HEALTH AND HOSPITALS CORPORAT

HHC 120-203 (JAN 73) REPLACES SR 8004

_____ Division _____ **HISTORY**

Name _____ Admitted _____ 19___ Ward _____ Chart No. _____

7 - patient appear agitated and uncooperative

P - patient pre op for surgery today
No indication to leave patient transferred
presenting.

Dar

7/23/90 cont. Nurse's notes
4am Refused & vital BP taken, uncooperative & agitated @ this time. —
5am Placed on 2 ~~safety~~ pt restraints for safety precaution: Wanted to get out of bed & remove all dressings & IV tubings & line. —
Valium 5 mg IVP by Dr. Dove. —
5 15/am Quiet @ this time. no acute distress noted. —
6am BP-130/90 P-110 R-22. Chemstrip 120-180 mg. Still uncooperative. — HElonigan RN
7Am I&O measured & recorded. EP&Y No significant changes in the pattern. Resting quietly @ this time. — HElonigan RN

7/23/90 Orth
Pt removed splint & [illegible] after [illegible] & wound
Ext: n/v [illegible] [illegible]: A+O×3. Affect inappropriate
Wound clean
A/P: Wound redressed
Splint replaced
Will [illegible] x-ray (L) [illegible]

B [illegible]

355

472

18

Division _____ HISTORY

Name _____ Admitted _____ 19__ Ward _____ Chart No. _____

7/23/90 8:00 am Nurses Notes Tour II

Patient received awake and agitated. Ventilating on room air. Patient is also hostile. States "I'm going to choke myself if you come near me." keeps holding on to the foley catheter. IVF infusing via (R) subclavian line. Splint on (L) arm off, removed by patient. Bullet wounds x-pair. Patient required to have dressing applied. Abdomen soft c (+) bowel sounds. able to move all extremities voluntarily. Chest leads in place and connected to cardiac monito. Cardiac pattern documented below. Patten shows normal sinus rhythm. Cardiac alarms on + set between 50-150 _____ gf. org RN

7/23/90 9:00 am P#4 alteration in cardiac pattern RT unknown etiology. IP#4 monito cardiac pattern for occurrence of PVC's; assess patient for any signs of cardiopulmonary difficulties: EP#4 no PVC's noted. no complaints of chest pain _____ gf. org RN

Seen by trauma team. Patient remains uncooperative. gf. org RN

7/23/90 10:00 am Blood drawn for ABG with ff. results: PO_2 - 60 PCO_2 - 36 Ph - 7.5 % sat - 92.9 HCO_3 - 27.8. _____ gf. org RN

7/23/90 11:00 am Property released to husband by patient. with 2 pierced yellow metal rings on property sheet _____ gf. org RN

7/23/90. 11:05 am Unifacal PVC's noted. Pattern documented on next page _____ gf. org RN

357

8:00 am 7/23/90 Mendez Josephine

473

Chart No. 117-35-00 F.

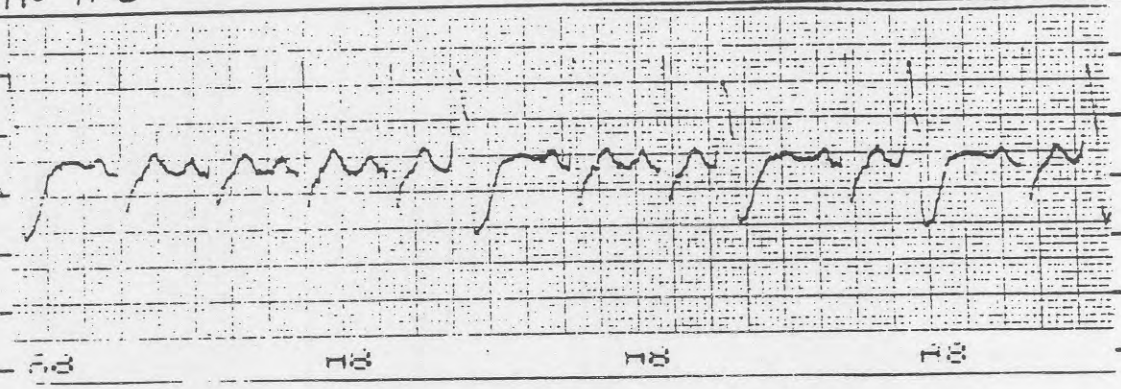
HOSPITAL HARLEM 961701-0

PROGRESS RECORD MENDEZ JOSEPHINE

Name 9-9-32 Admitted S- 19 Ward

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/23/90 11:00am Nurses Notes Tour II



7/23/90 12:00N. ~~Patient remains~~ P#5 Potential for injury RT confusion + agitation. Goal #5 Provide safety. PL#5 Prevent from injury. IP#5 stat dose of Haldol 2 mg IM. ordered by Dr. Boamah. maintain on 2 point wrist restraints. Pad side rails + board of bed to prevent injury. Inspect wrist restraint areas for any signs of decrease circulation such as change in color, loss of sensation + movements. EP#5 Patient is to remain + agitated. ——— gf. cng RN

7/23/90 12:40 pm received Haldol medication from pharmacy Patient received stat dose 2 mg of Haldol. Psych consult evaluation requested. Unable to give patient neuroleptic dose at 9am. Patient with no NGT. attempted to administer meds p.o. but patient refused and started to be combative. Dr. Boamah aware of patients behavior. ——— gf. cng RN

7/23/90 1:00 pm. Place on full liquid diet. Patient assisted c feeding but refused to eat ——— gf. cng RN

358

474

Continue Notes on Other

Division

HISTORY

Name Admitted 19 Ward Chart No.

7/ '90 2:00 pm Nurses Notes

Still unable to administer p.o. meds. Patient still refused to take ~~po~~ p.o. fluids including meds. Dr. Boamah aware. gf. ang Rn

7/23/90 2:30 pm Seen by psychiatrist for evaluation for restlessness & agitation. Patient refused to talk. Appears calm but just stares when talked to. gf. ang Rn

7/23/90 3:00 pm Blood gas done with ff. result: PO_2 - 59 PCO_2 - 39 Ph - 7.51 % sat - 92.6 HCO_3 - 27.4. gf. ang Rn

7/23/90 SICU RESIDENT'S NOTE

Pt. became confused and agitated this a.m. — seen by Psychiatry — No psych hx of psychiatric illness. (PT) had been treated on Hydrocortisone on 7/21/90. Other meds include Vancomycin + sucralfate. Pt had been off steroids for 1 year. (PT) has hx of bronchial asthma.

ABGs on room air show: PO2 stable at 59-60.

Lungs: clear.

Vitals: BP 120/80 T max 100.1 P - 118 R - 22.

Abd soft BS+

— no tenderness

Extremities: moves all extremities

(R) forearm splinted: good capillary refill

Labs

ABG 7.51 | 59 | [illegible] | 92.6 | 27.4. 359

R. A.

475

Division HISTORY

ne Admitted 19 Ward Chart No.

7/24/90

EP#5 4 pain ... maintained

... Q 2 HRS + range of motion

exercise given ... elevated

... no ... during ...

EP#4 patent airway maintained - No change

in ... pattern - No c/o pain ...

... when questioned.

EP#5 - No ... pt

cough + ... ~~...~~

General condition ...

NPO after midnight ... Oral surgery

dressing to the ... intact - ...

area ... drainage - Moderate

... D5 0.9% ...

@ 100cc/hr. - ... not ...

... pt slept well during the night

total urine output 600cc -

Chemistries / 20 - 180 mg/dl - - - ...

Continue to get KCl 20 ... in D5 1/2 NS

@ 100cc / hr. - rate ... - IV site to

(R) ... dry + intact - - - ...

... - ... wound + dressing - Bowel

sounds - Chest sounds breath sounds

... wheezing - ... even ...

... + NS - ... ...

362

477

Division HISTORY

Name Admitted 19 Ward Chart No.

CXR wnl

EKG sinus tachycardia with VPD's.

Blood Type A Rh +.

Consent to be obtained by primary oral surgery team surgeon give Hydrocortisone pre-operatively.

Bernard

7/24/90 Trauma Svc's Note

Tmax = 98.8. P97; R24; BP 154/90

I/O's 2760/3400

Labs: 11.1 / 10.5 / 30.5 — 145 / 110 / 85 — 5.5 / 25 / 0.6

Theophylline = 2.7.

Exam: Pt. very sleepy this am, and when awakened still non-cooperative.

Lungs: Clear ± occasional wheezes.

Cor: S_1S_2; (-) MM.

Abd: Soft, NT/ND, (+) BS.

Ext: moves all extremities well.

A/P: (1) Will continue ± Psychiatric recommendation of Haldol, however, may consider d/c'ing the dosing interval

(2) Hemodynamically stable.

(3) Will follow ± Oral Surgery on surgical repair of mandibular fx.

364

478

Ferrell

-11-

Chart No. 117 85 00

HOSPITAL HARLEM HOSPITAL CENTER

961701-0

PROGRESS RECORD

MENDEZ JOSEPH,NE

Name 0-A- Mendez Admitted ______ 19___ Ward ______

1-17 90

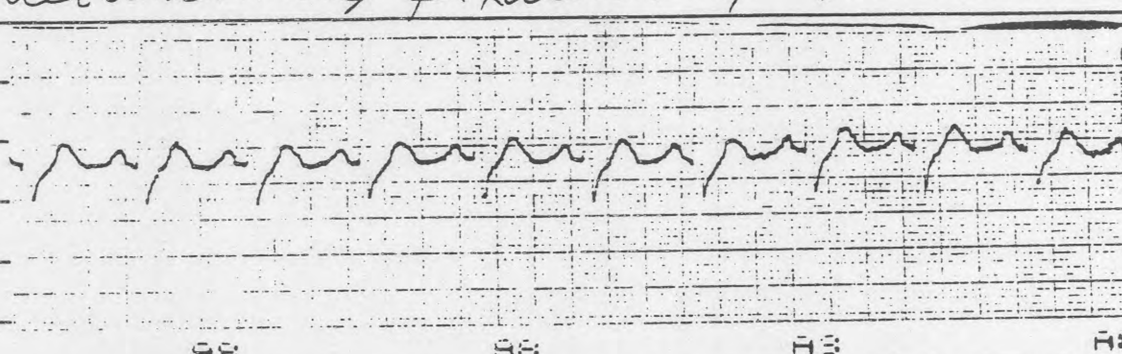
Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/24/90 nurse note

8A> received pt. awake, responsive to all stimuli. confused @ times. c̄ O2 n/c 4L/min. IVI infusing well via subcl. no sign of infection noted on site. foley catheter to RSB intact

9A> seen & examined by oral surgery

10A> consent signed for closed reduction c̄ intermaxillary fixation by husband.



NPO for OR. NGT med not given IV med given ______ [signature]

11A> P# 4 alteration in cardiac pattern R/ unknown etiology. P#4 on cardiac monitor alarm set at 70–50. EKG documented above

12N> no sign of resp distress noted. P# potential for injury R/T agitation & restlessness P#5 kept on 2 point restraints for safety prec ______ [signature]

Continue Notes on Other Side

479

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

366

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Chart No. 117-25-00 F.

HOSPITAL HARLEM 961701-0

PROGRESS RECORD MENDEZ JOSEPHINE

0-8-32 S

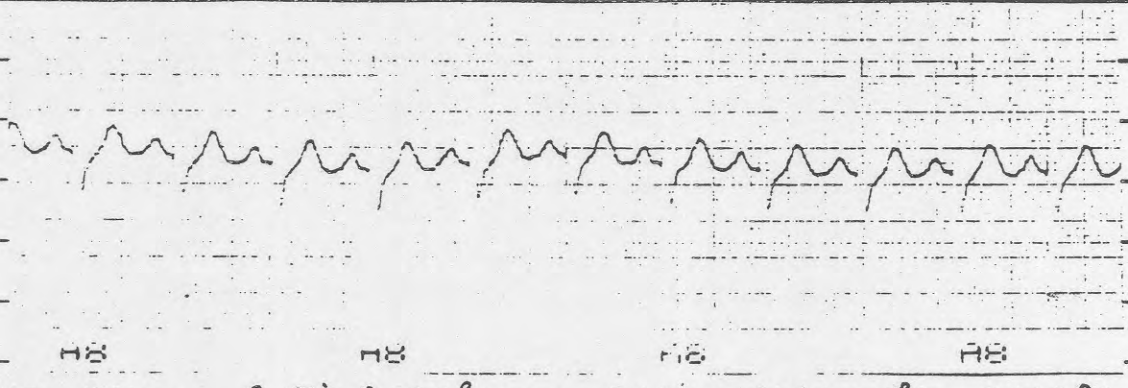
Name _____ Admitted _____ 19____ Ward _____

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

CBC
Smears } pending.
Imp: Stable hemodynamically.
Agitation - r/o steroid related; r/o "ICU Psychosis"
Plan: D/C Hydrocortisone
Sedation prn
D/C Vancomycin.

Roam, dr

7/23/90 4:00 pm Nurses Notes Tour III
Remains connected to cardiac monitor. Cardiac pattern documented below. Pattern shows normal sinus rhythm.



HB HB HB HB

7/23/90 5:00 pm Patient asleep. Opens eyes when awaken and responds to verbal stimuli. Seen by surgical team on rounds.

7/23/90 6:00 pm Asleep at the moment but easily awaken. Still confused & disoriented. Gf. ang RN

7/23/90 7:00 pm Seen by son. Periods of disorientation still noted. Unable to identify son at first. Gf. ang RN

Continue Notes on Other Si

476

NEW YORK CITY HEALTH AND HOSPITALS CORPORATIC

HHC 120-203 (JAN 73) REPLACES SR 8004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

_______ Division _______ **HISTORY**

Name _______ Admitted _______ 19___ Ward _______ Chart No. _______

7/24/90 nurses note

1p> EP#4 no EKG changes noted — A Sul

2p> EP#5 slept most of the day. no agitation noted — A Sul

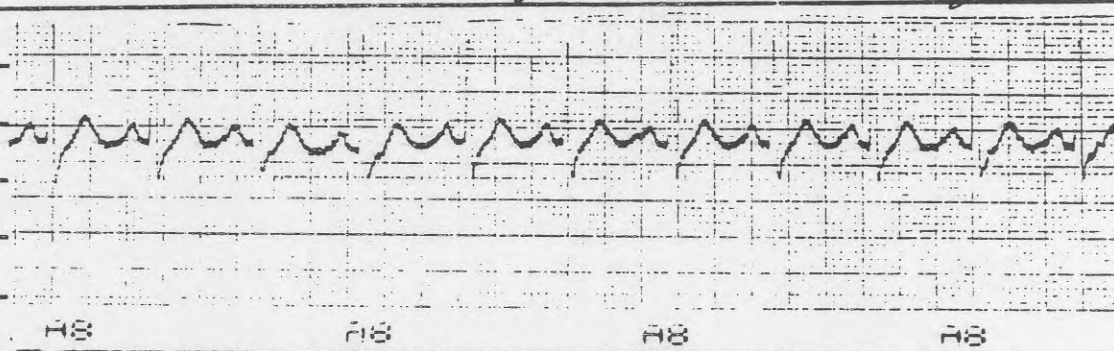
3p> due med given — A Sul

4p> seen & examined by Surgical team

4:40p> restless & agitated. screaming & noncoherent. MD made aware — A S

4:45p> stat dose of 2mg Haldol IM given — A

5p



EP#4 remains on continuous cardiac monitor. alarm set at 50-150. EKG documented above — A Sul

6p> afebrile. seen & examined by oral surgery — A Sul

7p> EP#4 no untoward changes noted on EKG — A Sul

8p> quiet & sleeping @ the time. no restlessness or agitation noted — A Sul

8:45p> flexiflo feeding tube inserted by MD premedicated c Valium 5mg IVP by Dr. Donaldson — A Sul

10p> no S/S of resp. distress noted — A Sul

480 > still awaiting X-ray on flexiflo feeding tube — A Sul

Chart No. 1172590

HOSPITAL Harlem

PROGRESS RECORD

Name MENDEZ, JOSEPHINE Admitted 19 Ward

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/24/98 5:30 P

OMFS: R3 POST-OP NOTE.

(1) Pre-op Dx: MAND FX S/P GSW to face.
(2) Procedure: (1) DEBRIDEMENT OF GSW (3) EXT #27
(2) BIPHASIC PIN FIXATION
(3) Post-op Dx: same as pre-op.
(4) SURGEONS: ATTENDING SURG: PATTERSON 1ST ASSIST: GANZ
(5) ANESTHESIA: GA (2) NT ANESTHESIA
(6) ANESTHESIOLOGIST: ATTENDING/CRNA
(7) EBL: 30 cc
(8) FLUIDS: 2300 cc CRYSTALOIDS
(9) PATHOLOGY: Tooth #27.
(10) DRAINS: 1/4 inch penrose Drain
(11) ~~ANOSIS~~ FOREIGN BODY: stent, biphasic pins, wire.
(12) INTRAOPNEW: (1) Hydrocortisone 100mg
(2) 2% Ld 1:10^5 epi → 12 cc
(13) CLOSURE: 3-0 DEXON DEEP, 5-0 nylon on skin
(14) COMPS: NONE
(15) PT TOLERATED PROCEDURE WELL WITHOUT COMPS AND WAS TRANSFERED TO RR INTUBATED BUT AWAKE, VSS, and WITH SPONTANEOUS RESPIRATIONS.

R3 2591

Continue Notes on Other Side

370

481

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

HHC 120-203 (JAN 73) REPLACES SR 8004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Division

Name Mendez, Josephine Admitted 19 90 Ward 1N Chart No.

HISTORY

7-26-90 - Nurses notes 8pm.

Pt. received from OR. Alert, responsive, c IVF infusing s infiltration or redness at insertion site. VS T98°, P72, R80, BP 120/80. facial external fixator in place to stabilized fx mandible Ice pack in place, arch wire in place. (L) arm - posterior splint, breathing is even s SOB or distress.

P#1 potential for respiratory distress

I.P#1 make wire cutter available at bedside have suction apparatus available. Keep in semi fowler's position — [illegible] RN

371

482

78

_______ Division _______ **HISTORY**

Name _______ Admitted _______ 19__ Ward _______ Chart No. _______

Patient has received 20meq KCl in IL IVF @ 100cc/hr.

? - Preop for surgery today, although a delay or postponement is anticipated.
Transfer to 11N.

Gore.

7/24/90 Oral & Maxillo-Facial Sx.

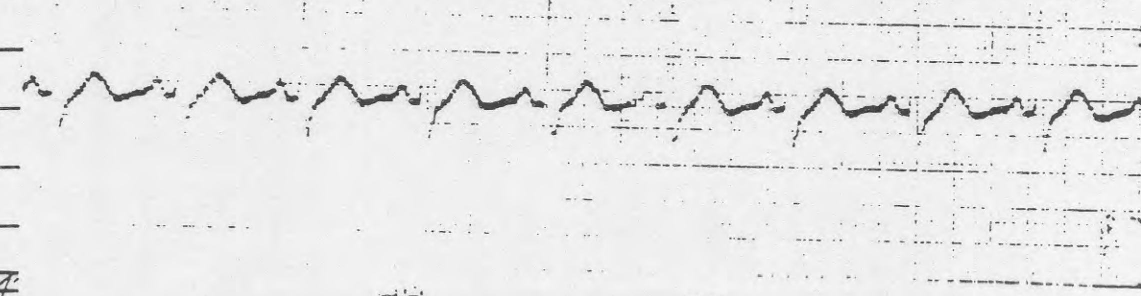
R/O is cancelled because of unavailability of operating room time to do planned procedure. Patient is booked for 7/25/90

[illegible] MS, IV.

7/25/90 Nurses Notes

12AM neuro: Alert & responsive to all stimuli c̄ lapses of disorientation & confusion. On 2 pt. restraint c̄ safety precaution.

Cardiac: On EKG monitoring c̄ strip taken & documented below. Sinus rhythm @ 80-150/min. BP 130/80 P- 95 R-24



373

483 ~~[illegible]~~

Peripheral pulses palpable.

* Resp: Ventilating on room air. No respiratory distress. *

Chart No. ____________

HOSPITAL HARLEM HOSPITAL CENTER

117-25-06 F.
961781-0
MENDEZ JOSEPH

PROGRESS RECORD

Name ____________ Admitted ____________ 19____ Ward ____________

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/25/ac cont. Nurse's Notes
noted. —
G.I.T. c̄ NGT in place & intact & clamped. Kept NPO for surgery ca_ tm as advised by MD. Abdomen soft, not distended. Bowel sounds (+). —
OUT: c̄ foley cath to B&D bag by gravity c̄ moderate urine output.
Integumentary c̄ multiple GSW on (L) arm, neck, chest & (R) arm. Dressings intact & dry. c̄ Dressing on (R) mandible in place. — Helonagi RN
1 AM Resting Quietly - IVF infusing well. —
1 30 Am K level - 2.9. started on KCl 20 meq in 100cc NS to run over 1 H. — Helonagi RN
2 AM B.P. 120/70 P- 90 R- 24 T- 99.1 asleep @ this time no unusual EKG changes noted. Relatively stable. —
3 Am Line medication administered as ordered by MD tolerated well. —
4 Am VS stable. No acute distress noted. —
5 Am Quiet in bed; remains on 2 pt. restraints. No distress noted. — Helonagi RN
6 Am Remain asleep @ this time. CVP - 9 Cm H2O Chemstrip 120-180 mg/dl. — Helonagi RN
7 Am I & O measured & recorded. EP#4 no unusual changes noted. EP#5 no agitation @ this time — Helonagi

Continue Notes on Other Side

374

484

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

00

Division HISTORY

Name Admitted 19 Ward Chart No.

1/25/90 SICU Transfer Note

57 yr old ♂ hx of branchial asthma sustained multiple GSW to face, neck chest and both upper extremities on 7/17/90. (Pt) was intubated in ER and admitted to SICU for ventilatory support. (Pt) sustained fx of the mandible and fx 4th x 5th meta carpal bases - being F/U by oral surgery and orthopedics. (Pt) was successfully extubated on 7/21/90 and now 4L oxygen by face mask. (Pt) became agitated and confused on 7/23/90 for which psychiatry was consulted and put on Haldol prn.

Pt now awaiting debridement of GSW to jaw and fixation of mandibular fracture. (Pt) dev. hypokalemia which has been corrected.

Labs from today

ABG 7.44/87/44.5/96.9/30

4L O2

CBC 10.9 \ 11.1 / 323 / 33.4

SMA7 137/103/8/164

3.9/25/0.7

Medications.

Theodur 300mg PO BID 377

Haldol 1mg I.M. q. 12H prn.

(Pt) should either be tube fed or put on full liquid diet as

455

Chart No. _____

HOSPITAL HARLEM HOSPITAL CENTER

PROGRESS RECORD

117-25-00 F.
961701-0
MENDEZ JOSEPHINE
9-8-32 S
1-17-90

Name _____ Admitted _____ 19___ Ward _____

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

Elevated. Follow theophylline levels.
Board

7-25-90 Nurses Note.

3 pm. Transferred in from SICU per stretcher with patient escort and Dr Dini. Assisted to assigned bed and settled to the floor. IV fluid infusing well. Foley catheter in place to BSD bag draining amber colored urine. Cast splint to @ arm is clean with arm bandage. Unable to move fingers. Pulses on @ upper forearm intact. Bruise on right face mark. Dr. Parikh made aware of the transfer. Patient with good skin turgor. Vital signs. BP 140/90 T=99.4 P=90 R=20.

Patient alert and responsive, seems to comprehend when communicated. Alteration in comfort KT pain. (GOAL) pain is minimized to a tolerable level in an hour.

PLAN. Keep patient in the most comfortable position possible. Will be seen by M.D. @ my RN

380

Continue Notes on Other Side

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

486

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

_____ Division _____ HISTORY

Name _____ Admitted _____ 19___ Ward _____ Chart No. _____

7/25/90 DMFS pre-op check list continues

Medical Consult obtained = moderate anesthetic / surgical risks.

NPO after midnight.

Psych consult obtain, spoke to Dr. Celestin

= D/C Haldol prior surgical procedure prn if pt agitated

T. [illegible] RN

7-25-90 - 11 pm. Nurses Note

Obs: [illegible] P.O. - [illegible] by Dr. Chi! Pt tolerated well.

Leola Marcus LPN

7-26-90 Nurses notes 6 Am

Alert in bed, oriented + responsive. IVF infusing in (R) peripheral line c aminophylline 600mg D5 1/2 NS

Foley catheter draining straw colored urine.

NGT in place for tube feeding. Restraints intact but not connected! (2) arm splint intact

[illegible] (R) hand, [illegible] + warm.

ND#6. Potential for injury r/t agitation + restlessness.

NP#5 Maintain quiet environment, keep guardrails up (4), keep restraints ready, observe pt. frequently.

HC [illegible] RN

333

487

[redacted]

[redacted]SO

Chart No. ____________

HOSPITAL 30

961/01 PROGRESS RECORD

MENDEZ JOSEF VE

Name ______ Admitted ______________ 19____ Ward ____

7 17 90

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7-26-90 Nurses Note.

9am. Alert, responsive with IV fluid of D5 1/2 NaCl infusing well. For surgery today. NPO maintained. NGT in place, clamped. Foley catheter in place draining amber colored urine. Cervical collar rigid and untwisted.

9 30 am. To Oral surgery clinic per stretcher with escort [illegible]

10 30 am. Back from Oral surgery clinic. No distress noted. Assisted back to bed.

11 25 am. To O.R. per stretcher with patient escort. No pre medication written for medication. Vital signs BP 120/60 T=10[illegible] P=94 R=24. [signature] RN

O.M.S! Attending Note 7/26/90

This 57 y/o H.F. was Admitted on 7/17/90 c̄ a Dx of Multiple G.S.W. to the Face, chest and upper Extremities. Clinical and Radiographic Exam Reveals a Bilateral Fractured Mandible, A mandibular Anterior Dento-Alveolar Fx and a Oral Cutaneous communication. P.MH. (+) Asthma, Allergies - (+) PCN. Exam Reveals Bilateral Fx mandible, (+) mobility #31, mobility of mandibular DentoAlveolar Segment. Oral Cutaneous communication. IOAT

Continue Notes on O

NEW YORK CITY HEALTH AND HOSPITALS CORPOR

438

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

04

Chart No. ___
HOSPITAL Harlem

PROGRESS RECORD

1?7-?3 00 F
961701-0
MENDEZ JOSEPHINE
0-8-32 S-

Name ___ Admitted 90 19___ Ward 11

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7 27.90 Nurses Notes

10am. Alert and responsive, with IV fluid of D5 1/3 NaCl 1: 377 ing Cinary infusing well. Fixator pin on R side of the face intact. Crusted with a.m. care. [illegible] on Humidified O2. Placed in the most comfortable position possible. Medicated for pain with relief. Foley [illegible] discontinued. Voiding freely. [illegible] RN

7-27-90 Nurse Notes

5P- Awake, alert & responsive, receiving IV therapy, c fixator pin on (L) side of face, continues to receive O2 therapy via venti mask, (L) arm posterior splint intact — [illegible] RN

7P #1 Potential for respiratory distress

IP#1 VS taken BP 140/90 P86 R-20 T98.4, O2 therapy continues, suction at bedside — [illegible]

7/27/90 Trauma Chief Resid Ple

Pt is ~~[illegible]~~ cleared from general surgery and may be transferred to Oral Surgery ~~for~~ further Mgt.

[signature]

030 Continue Notes on Other Side

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

489

HHC 120-203 (JAN 73) REPLACES SR 8004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Chart No. _____

HOSPITAL Harlem

PROGRESS RECORD

961701-J
MENDEZ JOSEF . VE
S-

Name _____ Admitted 7-0 19__ Ward 1 C

Observations and Opinions of Visitings, Consultants and House Staff.
A final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/27/90 Nurse NOte

10P EP#1 No respiratory distress noted — prob by mo —
P#2 comfort alteration due to pain
- IP#2 assisted in pm care, receiving medication for pain EP#2 verbalized relief from pm medication —— prob by mo ——

7-27-90 Nurse's Note!
Obs: bed for short period of time. Continues on IV fluids & antibiotics for asthma relief. Ambulates at bedside. Encouraged to move about in bed. Voiding sufficient quantity. All Lab Slips & pins intact. Able to take P.O. —— D. Marcus LPN

7/27/90 OMFS Fellow NOTE — Procedure NOTE
1010 PT 1 day S/P extraction of tooth, debridement of wounds, & external fixation placement.
S: PT STATE is happy in her new location & in need of some medication to help her sleep.
O: BP: 140/90 P: 84, R-20 Temp 98 I.V. PATENT - PT AAOX3
External fixator in place & STABLE, intra oral in place & STABLE
- PT RESTING Comfortably in bed PT got up to use REST Room
- HEART-Normal S, S2 Sounds; LUNGS Clear to A&P; ABD Soft non-tender
- Intraoral ⊕ ⊕ Plaque. ⊕ Induration & edema paresthesia in mental area Bilateral
A- PT 1 day POST OP Reduction & fixation of Communited fx
PT in need of POST OP Radiographs be further Diagnosis

-over-

332 Continue Notes on Other Side

490

HHC 120-203 (JAN 73) REPLACES SR 8004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Chart No. _____ BMC 461701-0

HOSPITAL _____ MENDEZ JOSE [illegible]

8-8-22 S-

PROGRESS RECORD 7-17 90

Name _____ Admitted _____ 19____ Ward ____

Observations and Opinions of Visitings, Consultants and House Staff.
A final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/22/90
9:30pm Rx acceptance Note

This is 57410, HX, admitted on 7/17/90 for multiple GSW to face, chest and upper extremities, Pt was intubated in ER and under observation at AICU. During the course of hospitalization, post traumatic psychosis was diagnosed, haldol was given prn as suggested by psych consult. PVC's noted in EKG, medical consult thought it was due to possible hypoxia, Theophylline Toxicity, hypokalemia or electrolyte imbalance; No antiarrythmia medications was recommended. Pt was extubated on 7/22/90, Subsequently transfered to TRAuma Service for further management. On 7/26/90, Pt was then taken to O.R. for reduction of B/L mandible fx and debridement of GSW sites, and closure of ~~extra~~ oral-Cutaneous communication as result of GSW. External pin fixation was placed at mandible, as well as Fabrication of stent to stabilized alveolar fragments

334

Continue Notes on Other

491

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

HHC 120-203 (JAN 73) REPLACES 3R 3004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Division _____ HISTORY

Admitted _____ 19___ Ward _____ Chart No. _____

OMF injury =

S/p External Pin fixation, Stent insertion & Circummandibular wires and Closure of Oral Cutaneous Communication, of B/L mandible fx and Alveolar fx,

Plan = 1) Continue Supportive care
2) Continue IV Antibiotic Therapy.
3) Oral Saline rinse TID.

[illegible] RN

7/29/90 at 12³⁰ am A: Sleeping & HOB > approx 40° Color good. No resp distress noted. Using humidified O2 40% via face test. External pin fixation in place. No sign of infection noted on the sites. Has IV of ½NS + 1gm Vit C + 10cc MVI via pump at 60cc/hr. Has ① splint cast on. Wiggles ⑤ fingers & difficulty. Fingers warm to touch. Color pink. P#4 Alteration in cardiac pattern resolved P#5. Potential for injury and P#6 Potential for respiratory distress noted. EP #5. Reading quietly at this time. EP #6. No resp distress noted.

CP Nancy RN

397

492

Chart No. _____

HOSPITAL _____ 901701-0

MENDEZ JOSEFINE S

PROGRESS RECORD

Name Mendez, Josefina Admitted _____ 19____ Ward _____

Observations and Opinions of Visitings, Consultants and House Staff.
Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/29/90 8:00A Oral & Maxillofacial Surgery.

3 POD.

Patient is alert oriented and responsive. No acute distress. Lying in the supine position.

- External bifocal pin is intact and stable. Xeroform gauze at the pin - soft tissue interface is removed. No soft tissue swelling noted.
- Penrose drain at R mandibular area is intact. Less than 1 cc of drainage. Drain is removed and sterile dressing placed.
- Oral hygiene very poor with accumulation of saliva at the surgical sites.
- Occlusal stent is intact and stable and circummandibular wires are also intact.
- IV is infusing well.
- Orthopedic splint to the ⓡ forearm is intact. Can move all fingers.

Continue Notes on Other Si

493

NEW YORK CITY HEALTH AND HOSPITALS CORPORATK

HHC 120-203 (JAN 73) REPLACES SR 8004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

7/29 Ortho
AVSS
Ulnar gutter intact
Sensation intact
Good cap refill

Plan Ulnar gutter x 6 wks
Discussed c Dr Azzo

R. Jelume

7/29/90 1pm nurse's note
A→ ~~[illegible]~~ alert, responsive, oriented x3 r/t jaw swelling sutures c dressing external fixation pin r/t jaw intact. dressing ace bandage and splint L/t hand c arm intact. fingers of ~~L/t~~ hand ~~warm~~ to touch, able move, color good, elevated on pillow OOB on chair with assist also to BR. IV. r/t SWB in progress.
P#3 alteration in comfort r/t pain ~~due to trauma~~ c
I P#3. assist in ADL and feeding will offer pain med as ordered. apply splint under L/t arm c elevated L/t arm at all times
E P#3. No severe pain noted. ADL c assist.
P#6 potential for resp distress r/t surgical procedure
I P#6 HOB apply humidifier O2 via face tent. V.S to be monitored q shift ~~will receive med. on time~~
E P#6. No resp distress. elevated HOB at all times
V.S. normal pt received Theodore ~~[illegible]~~ [illegible]

494

401

Q1

Chart No. _____ Male

HOSPITAL _____

PROGRESS RECORD MENDEZ JOSEF ME
0-9-32 S-

Name _____ Admitted _____ 19____ Ward _____

Observations and Opinions of Visitings, Consultants and House Staff.
A final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/29/90 OMFS P.M. Note

Patient is 57 y.o. hispanic female 2 day S/P extraction of tooth #27, wound debridement and skeletal pin fixation.

S. - Patient complains of minor pain in jaw

O: Patient asleep and lathargic - no apparent swelling. I.V. patent - 3cc blood tinged discharge noted on dressing. External fixation intact - stent stable

Vitals: Bp. 150/90 T. 98.4 P 82 R. 20

Lungs: CTA bilaterally all fields

Heart: ⊕ S_1, S_2, ⊖ murmur

ABD: ⊕ Obesity; no mass, non tender negative organomegally.

Impression: Maxil. fx S/P GSW to face

Plan: ① Bacitracin ointment @ fixation site

② Irrigation of oral cavity.

③ Continue I.V. antibiotics

④ Supportive care

Tx: Irrigation of oral cavity w/ Sterile Saline 4:2

New dressing placed.

S. Shepheard DDS

P64

Continue Notes on Other Side

495

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

HHC 120-203 (JAN 73) REPLACES 3R 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Chart No. ________ [redacted]

HOSPITAL ________ [redacted]

PROGRESS RECORD

Name ________ Admitted ________ 19____ Ward ________

Observations and Opinions of Visitings, Consultants and House Staff.
A Final Discharge Note Must Be Entered on This Sheet. Sign and Date Every Entry.

7/31/90 OMFS 11:30 am

Dx: pt s/p closed reduction of bilateral mandible comminuted fractures c̄ external pin fixation extraction tooth #27, and gun shot wound debridement.

S: ~~pt ... alert + oriented X3~~
pt reports no problems.
Complaint of slight pain in mandible

O: pt is alert + oriented x3
Vs BP 140/84 P 84 R 18 T 98.6
Abdomen: soft nontender, Normal bowel sounds
Lungs: Clear to auscultation + percussion
Heart: (+) S1, S2, (−) murmurs
E.O.E: External pins + fixation intact
No obvious swelling / pathology noted
I.O.E: acrylic splint intact
pt hygiene less than adequate
No I.O. swellings, discharge noted

A: pt stable

P: (1) physical therapy consult
(2) continue IV antibiotics
(3) plan to D/C 8/1/90

[signature] DDS PGY-1

406

Continue Notes on Other Side

496

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

HHC 120-203 (JAN 73) REPLACES SR 5004
WHICH WILL BE USED UNTIL EXISTING SUPPLY IS EXHAUSTED

Division HISTORY

Admitted 19 Ward Chart No.

7. 31. 90 Nurses Notes.

6am: Alert and responsive with 1U [illegible] of D.45 NaCl infusing well. Assisted with a.m. care. External fixator on mandible in place. Dressing on (L) arm in place with ace wraps and splint. (L) fingers warm to touch. Mobile, elevated on a pillow. To [illegible] [illegible] in [illegible] chair and came back.

P-U 3. Alteration in comfort RT pain continues.

PH 6. Potential for respiratory distress RT surgical procedure.

IPH 3. Medicated for pain as ordered by M.D. Placed in the most comfortable position possible. Assisted with complete care.

EPH 3. Verbalized feelings of comfort. ↓ pain.

EPH 6. No respiratory distress noted. Head of bed elevated at all times. [signature] RN

7/31/90 Derm see consult sheet. [signature]

497

8-1-90 Nurses Notes

8 am - Alert and responsive. Seen by M.D during rounds. For discharge today. Instructed to come back to Oral surgery clinic on 8-3-90 at 9 am. Medication: Bacitracin ointment to ® jaw, Tylenol #3 1-2 tabs PO q4hrs PRN pain, Theodur 100 mg PO TID, Ilosone 600 mg. 1 tab Q6 hrs x 7 days. Prescription and clinic appointment given. Instructed to have only liquid diet & not to get involved in contact sports. Verbalized understanding [illegible]. To home c daughter. Instructed [illegible] [illegible] [illegible] to doctor [illegible]. [illegible] RN.

410

498